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DEPARTMENT OF
 PUBLIC HEALTH AND HUMAN SERVICES



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John Smith
 123 Road
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Case #: 821529
 Document #: 15502289
 Print Date: 01/20/2016
 Contact Phone: 1-888-706-1535

Your Case Number

About Your Case

Dear John Smith,

The first part of this letter is a summary of your benefits.

Please report changes according to each program's reporting requirements so your benefits can be determined correctly.

Health Coverage

Your health coverage information is listed below. Please read this entire letter.

Date of Application: 01/20/2016

Effective Date	Action	Person(s)	Monthly Charge	Explanation
01/01/2016	Approved	John Smith	\$24.00	For more information, please see the Information on Your Health Coverage, Additional Services Available to You , and Your Health Coverage Change Reporting Requirements Section.

¹This health coverage is dependent upon waiver approval from Centers for Medicare and Medicaid Services (CMS). The premium amount may be reduced or eliminated for some individuals based on final approval from CMS.

Coverage begin date

Eligibility status

Monthly Premium you are responsible to pay